STATE OF NEBRASKA
HEALTH & HUMAN SERVICES REGULATION & LICENSURE
CREDENTIALING DIVISION
P. O. Box 94986
Lincoln, Nebraska 68509-4986

AFFIDAVIT OF PERSONAL RECOMMENDATION FOR REINSTATEMENT

STATE OF _____)
)
COUNTY OF_____)

_____, being first duly sworn or affirmed,
(Name of Affiant)

deposed and says: I, _____ of
(Name of Affiant)

_____
(Street Address) (City) (State) (Zip Code)

hereby state that I have personal knowledge of the activities of _____

_____ since the revocation was imposed on
(Name of Pharmacist)

_____. I am not related to _____
(Date) (Name of Pharmacist)

To the best of my knowledge and belief, he/she is of good standing and is of good moral character. I hereby recommend this person in all respects as worthy to be licensed to practice Pharmacy in Nebraska.

COMMENTS:_____
_____

_____
(Legal Signature of Affiant)

Subscribed and sworn or affirmed before me this _____ day of _____, 20_____.

S E A L _____
(Signature of Notary Public)

My commission expires _____

FORWARD THIS COMPLETED FORM TO: ATTN: Pharmacy Desk
HHS Regulation and Licensure
Credentialing Division
P. O. Box 94986
Lincoln, NE 68509-4986